Form A

Attending Physician's Statement
診 療 内 容 明 細 書

1. Name of Patient (Last, First) Age (Date of Birth) Sex (Male·Female)
   患者名 _____ 年齢(生年月日)_____ 性別(男·女)_____

2. Name of Illness or Injury preferably with Number of International Classification of diseases for the use of National Health Insurance
   傷病名及び国民健康保険用国際疾病分類番号

3. Date of First Diagnosis: D / M / Y ____/____/____
   初診日 日 / 月 / 年 ____/____/____

4. Duration of Treatment: _____ days
   診療日数 _____ 日

5. Type of Treatment
   治療の分類
   - ☐ Hospitalization: From ____/____/____ , to ____/____/____ (days)
     入院 自 ____/____/____ 至 ____/____/____ (日間)
   - ☐ Out patient or Home Visit: ____/____/____ ____/____/____
     入院外 ____/____/____ ____/____/____

6. Nature and Condition of Illness or Injury (in brief)
   症状の概要

7. Prescription, Operation and Any other treatments (in brief)
   処方、手術その他の処置の概要

8. Was the treatment required as a result of an accidental injury? Yes☐ No☐
   治療は事故の傷害によるものですか。 はい いいえ

9. Itemized Amounts paid to Hospital and/or Attending Physician: Form B
   治療実費 様式B

10. Name and Address of Attending Physician
    担当医の名前及び住所
    Name 名前 : Last 姓 First 名 Title 称号
    Address 住所 : Home 自宅 phone電話
    Office病院又は診療所 phone電話 -

Date 日付: _____ Signature 署名 _____
Attending Physician担当医

Reference Number of your Medical Record (if applicable)
診療録の番号 _____